

FOR OFFICE USE ONLY	Case # _____	Counted Y <input type="checkbox"/> N <input type="checkbox"/> → <input type="checkbox"/> Trans-In <input type="checkbox"/> Non TB <input type="checkbox"/> Reactivation	Source Case # _____
	MMWR Date _____		

NEW REPORT	TUBERCULOSIS CASE REPORT Washington State DOH STD/TB Services PO Box 47837 Olympia, WA 98504	Date Submitted <div> <div><input type="text"/></div><div><input type="text"/></div> <div><input type="text"/></div><div><input type="text"/></div> <div><input type="text"/></div><div><input type="text"/></div><div><input type="text"/></div><div><input type="text"/></div> </div> Month Day Year	Client ID # _____
		Transfer-In? <input type="checkbox"/> Yes <input type="checkbox"/> No	TIMS # _____

CLIENT INFORMATION			
CLIENT NAME Last _____ First _____ Middle _____ Alias _____		CLIENT DOB: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female RACE: (select one or more) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian Specify _____ <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander Specify _____ ETHNICITY: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
STATUS AT DIAGNOSIS <input type="checkbox"/> Alive <input type="checkbox"/> Dead ↓ Date: _____			
ADDRESS Street _____ Apt. # _____ City _____ County _____ ZIP _____			
COUNTRY OF ORIGIN <input type="checkbox"/> U.S. <input type="checkbox"/> Other → Which country? _____ → Date entered U.S. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Did client enter country as: <input type="checkbox"/> Class A <input type="checkbox"/> Class B1 <input type="checkbox"/> Class B2	
Previous Diagnosis of Active TB Disease <input type="checkbox"/> No <input type="checkbox"/> Yes → Year of DX _____ <input type="checkbox"/> More than one episode		PREVIOUS TREATMENT FOR LATENT TB INFECTION? <input type="checkbox"/> No <input type="checkbox"/> Yes → Dates: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Year Month Year	
Previous Therapy: _____			

DIAGNOSTIC INFORMATION				
MAJOR SITE OF DISEASE: _____ Additional Site: _____		SKIN TEST Date Given: _____ By: _____ Date Read: _____ By: _____		
		RESULTS <input type="checkbox"/> Negative <input type="checkbox"/> Positive → Induration in mm: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not Done		
Fluid Specimens	Date(s) Collected	Smear	Culture	Biopsy Specimens for histopathology & Culture
		Pos Neg Pend Not done	Pos Neg Pend Not done	
Sputum(s)	_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Lymph node <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Pleura <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Bone <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Other <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Bronchial Wash	_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Gastric Aspirate	_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Pleural Fluid	_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Urine	_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Other _____	_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Date results received: _____				

X-RAY		
View _____ Date Read _____ Date Taken _____ By _____	Interpretation <input type="checkbox"/> Normal <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <input type="checkbox"/> Abnormal → <input type="checkbox"/> Cavitory <input type="checkbox"/> Non-cavitory → <input type="checkbox"/> Consistent with TB <input type="checkbox"/> Inconsistent with TB	Status <input type="checkbox"/> Stable <input type="checkbox"/> Worsening <input type="checkbox"/> Improving <input type="checkbox"/> Unknown

INITIAL DRUG REGIMEN					Date Rx Started: _____
<input type="checkbox"/> Isoniazid <input type="checkbox"/> Rifampin <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Combination therapy	<input type="checkbox"/> Ethambutol <input type="checkbox"/> Streptomycin <input type="checkbox"/> Ethionamide	<input type="checkbox"/> Kanamycin <input type="checkbox"/> Cycloserine <input type="checkbox"/> Capreomycin	<input type="checkbox"/> P.A.S. <input type="checkbox"/> Amikacin <input type="checkbox"/> Rifabutin	<input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Ofloxacin <input type="checkbox"/> Other _____	FREQUENCY: <input type="checkbox"/> Daily <input type="checkbox"/> Twice Weekly <input type="checkbox"/> Other _____ <input type="checkbox"/> Supervised <input type="checkbox"/> Unsupervised

RISK FACTORS FOR TB	
Mark those applying to clients <u>within the past 12 months</u>: <input type="checkbox"/> Homeless <input type="checkbox"/> IV drug use <input type="checkbox"/> Non-IV Drug Use <input type="checkbox"/> Excess Alcohol	Mark those applying to client <u>at time of diagnosis</u>: <input type="checkbox"/> Resident of correctional facility If yes: <input type="checkbox"/> Federal Prison <input type="checkbox"/> Local Jail <input type="checkbox"/> Other Correctional Facility <input type="checkbox"/> State Prison <input type="checkbox"/> Juvenile Correction Facility <input type="checkbox"/> Unknown <input type="checkbox"/> Resident of long term care facility. If yes: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Mental Health Residential Facility <input type="checkbox"/> Unknown <input type="checkbox"/> Hospital-Based Facility <input type="checkbox"/> Alcohol or Drug Treatment Facility <input type="checkbox"/> Residential Facility <input type="checkbox"/> Other Long Term Care Facility
Occupation: Mark all that apply within the <u>last 24 months</u> . <input type="checkbox"/> Health care worker <input type="checkbox"/> Migratory agricultural worker <input type="checkbox"/> Not employed within last 24 mos. (Including housewife, retired, student, etc.) <input type="checkbox"/> Correctional Emp. <input type="checkbox"/> Other employment <input type="checkbox"/> Unknown	

HIV INFORMATION	
HIV TESTING: HIV Test Offered <input type="checkbox"/> Yes <input type="checkbox"/> No HIV Test Given <input type="checkbox"/> Yes <input type="checkbox"/> No HIV Status <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Test Done, Results Unknown <input type="checkbox"/> Refused Testing	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">HARS No. _____</div> If positive, based on: <input type="checkbox"/> Medical Document <input type="checkbox"/> Client History <input type="checkbox"/> Other _____

ADDITIONAL INFORMATION		
PRIMARY TB CASE PROVIDER: Facility Name _____ Clinician _____ DOT PROVIDER: Facility Name _____ Clinician _____	INSURER: <input type="checkbox"/> MSC <input type="checkbox"/> Group Health <input type="checkbox"/> Health Plus <input type="checkbox"/> Kaiser <input type="checkbox"/> Qual Med <input type="checkbox"/> Other _____	PAYER: <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Self

COMMENTS